IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

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|---|---|
| Application No.: | 09/919,747 |
| Inventor: | Joseph C. Murray |
| Filing Date: | 08/01/2001 |
| Title: | Insulating Packaging Material and Related Packaging System |

**SECOND SUPPLEMENTAL DECLARATION OF JOSEPH C. MURRAY**

1. I am the inventor for U.S. Patent Application No. 09/919,747 ("the '747 application"). I am also president of Assignee ThermaFreeze Products Corporation. I have reviewed the Patent Office's response to our petition to revive the '747 application. I am submitting this additional supplemental declaration to provide additional facts as requested by the Patent Office, as best as I know them, in support of the renewed Petition to Revive for this application.

2. As I have said previously, neither my original company, nor my current company, nor I **ever had any intention of letting this application go abandoned at anytime for any reason**, nor could we have done anything else in our power to ensure that a response was filed to the last Office Action (or any, for that matter) in a timely manner.

3. The Patent Office wants an explanation of the facts of what happened before the '747 application went abandoned in May 2005, and then again between June 2006 and July 2007. A more detailed discussion of our activities and intentions during both of these time periods, along with a review of relevant documents, follows.

**Period Leading up to May 2005 and Thereafter**

4. During 2002-2005, as mentioned in my earlier Declaration, I was extremely ill from cancer and the associated surgeries and treatments. Since the Patent Office appears to be unsatisfied with my statements to this effect, attached as Exhibit A is a true and correct copy of my surgical records, and attached as Exhibit B is a true and correct copy of my chemotherapy records. Exhibit A was obtained from Springhill Memorial Hospital of Mobile, AL, and Exhibit B was obtained from Infirmary West, Oncology and Infusion Services, also of Mobile, AL. These records are as complete a record as I possess. Despite my poor health, I still kept in contact with Mr. Pugh periodically. What contact I did have essentially consisted of the instructions to "maintain the patents", which included the '747 application. During that period, I sent and received a number of e-mails to and from Mr. Pugh to this effect. Unfortunately, I no longer have them, because a nearby lightning strike during Hurricane Katrina in 2005 caused a power surge that destroyed the computer I was using at the time. Even so, Mr. Pugh had assured me that he would maintain the patents as instructed and that he would work on the '747 application when the time came. The time apparently came and went, and I was never informed by Mr. Pugh. I thought that by expressly instructing my patent attorney not to abandon the '747 application that it would be properly maintained, and that if the Patent Office asked for additional documentation or information regarding the '747 application, I would be informed. I thought that was the express role of a patent attorney.

5. At no point from 2002-2005 did Mr. Pugh mention to me --or, to my knowledge, anyone else at or connected to my company-- that he had received an Office Action or

any other such communication from the Patent Office. It was only on September 28, 2007 that I became aware there ever was a 2005 Office Action, from Mr. Negrin, one of my current patent attorneys at Pryor Cashman. Mr. Negrin was the first person to tell me or anyone else at ThermaFreeze that the '747 application was abandoned, and that Mr. Pugh has actually let the application go abandoned three different times. As I have said earlier, I was completely unaware of any of the three abandonments of the '747 application until September 28, 2007.

6. Around the time of the '747 application's abandonment in May of 2005, I underwent my second major surgery in which a baseball-sized tumor and 20% of my liver were removed. During the rest of 2005 and the first portion of 2006, I underwent very extensive chemotherapy. At some point during that period, I did inquire of Mr. Pugh as to the overall status of the portfolio, the specific payment of the maintenance fees, and the status of the pending (or so I thought) '747 application. He reassured me that everything was being taken care of and in order. I had no way of knowing that that statement was inaccurate. He never mentioned that the Patent Office had examined the '747 application. All of the correspondence from the Patent Office went to Mr. Pugh, none of it went to me or anyone else at the company. No one but Mr. Pugh knew what was going on with the '747 application, and he never shared it with us. To this day, I have no idea why he let it go abandoned despite my instructions and intentions to the contrary.

7. Unfortunately, no one can speak to Mr. Pugh now regarding why he let the application go abandoned three times, most recently in May of 2005. He is completely debilitated after two massive strokes and can answer no questions.

8. When Bob McGuire visited Mr. Pugh's office in Connecticut in November 2007, Mr. McGuire had indicated to me that Mr. Pugh's wife was going to call me. I had hoped that when she called, I would have an opportunity to try to obtain our files from her. She never called me, and now that the Pughs have reportedly moved away from their Connecticut home that also served as Mr. Pugh's office, I have no way to reach her or him. Consequently, there is no way of telling why he let my patent application go abandoned three times or why he never acted at all in response to the 2005 Office Action.

**June 2006-July 2007**

9. As I indicated in my previous Declarations, I was diagnosed as cancer-free on June 6, 2006. I began to re-assume the duties and responsibilities of attempting to commercialize my inventions almost at once. As part of revitalizing our company, I had the responsibility to refurbish an 18,000 square foot building, including getting a new roof on it. I also had to oversee --and sometimes personally physically accomplish-- the moving of production equipment, office furniture and equipment, etc. into the new facility at the lowest cost and maximum efficiency possible. During the period of June 2006 through July 2007, I was often working 18 hours a day, seven days a week to get

the business up and running. At this point, I was still unaware that the Office had ever examined the '747 application, let alone that a response to it was never submitted. (Id.)

10. In my previous Declarations, I described how in June 2006 I telephoned Mr. Pugh to determine the status of the patent portfolio, whereupon he suffered a major debilitating stroke while we were speaking on the telephone.

11. After that telephone call, over the course of the next several months, I made numerous attempts to try to reach Mr. Pugh. On one occasion, I spoke with his wife, who indicated he was not well, that he actually had suffered a second major stroke on the other side of his brain. On at least one subsequent occasion, I was able to reach Mr. Pugh directly. In none of our post-stroke telephone conversations was Mr. Pugh coherent nor did Mr. Pugh make any sense. It was impossible to speak to Mr. Pugh about anything pertaining to patents.

12. For several months after July 2006, we did not know if Pugh would recover sufficiently to return to work, and he had all the files and records. It was not germane to pressure Pugh for some time after his strokes, as he was in the hospital and recovery, and since we had no idea the '747 application had been abandoned (or even that an Office Action had been sent by the Patent Office in the first place). I had known other individuals to suffer significant strokes and sufficiently recover to return to their jobs, so it was not inconceivable that Mr. Pugh could do the same.

13. As time went on I called their home every two to four weeks for the next year, i.e., until June 2007. Those calls were placed at all times of the day and evening. I left a number of messages, but my calls were never returned.

14. During that period, I became increasingly and deeply concerned about the status of the patents and the '747 application, the last one that Mr. Pugh worked on for us. I felt that there had to be records in Mr. Pugh's office that should be harvested for us but I could not reach anyone, anywhere. As time moved into 2007 I became more and more concerned about the '747 application, but I was not as concerned about the existing patents since the funds for those maintenance fees had already been sent to Mr. Pugh by Mr. McGuire for payment to the USPTO. (As it turns out, the maintenance fees for those earlier patents were not paid either.)

15. At the end of 2006 and the beginning of 2007, it became clear to us that we needed to find new patent counsel. I first looked in nearby Mobile, AL but found no one who could help us in this regard. As we moved into 2007, I became aware that I was probably not ever going to reach Pugh again; in fact, at the time, I literally did not know if he was alive or dead, and I could not find out, since I could not get anyone on the phone at his home/office. In late winter/early spring 2007, I began to search for a patent attorney in Birmingham or Atlanta, although the fees for firms in these areas were huge compared to Pugh's. We had spent a tremendous amount of money on the patent portfolio, and we wanted to ensure that our next patent attorneys would be the right fit for

us. So we conducted our search for new counsel methodically, wholly unaware that our portfolio was already in jeopardy.

16. During this period and towards the end of the spring of 2007, we realized our company needed to reorganize and recapitalize. During the early summer of 2007, we retained Pryor Cashman for these purposes. Since Pryor Cashman also has capable patent counsel, we decided not to look further for other patent attorneys elsewhere. As soon as Messrs. Negrin and Langsam of Pryor Cashman were on the case, things moved quickly, and we were kept in the loop on all of our matters before the Patent Office, including the status of the '747 application. The details of my interaction with the patent attorneys at Pryor Cashman appear in my previous Declaration.

**Epilogue**

17. I finally had a return call from Mrs. Pugh on December 5, 2008 from one of the many voice mails that I left over the preceding months or longer ago. Mrs. Pugh told me that she and Mr. Pugh are now living with children in New Hampshire. She said that the only time they get back to their Connecticut home (and Mr. Pugh's former office) is for Mr. Pugh's physical therapy. She reiterated something that she said after Mr. Pugh had his strokes, to wit, they ignore checking the Connecticut voice mail almost all the time since Mrs. Pugh is totally concentrated on being a caregiver for Mr. Pugh. They are very focused on whatever recovery he can make. She resigned her job to take care of him full time.

18. She asked me if I would like to talk to him and I agreed. She said she'd call for him the next morning (Saturday, December 6, 2008) since he was not doing well at that moment. The following morning, I spoke to him briefly, about three or four minutes. His speech is labored but somewhat improved from the time I last spoke to him in the hospital back in 2006 between his first and second strokes. Apparently, the only things he remembers about me (or was prompted to recall by Mrs. Pugh) is that he and I were on the phone when he had the first stroke and I was able to get his wife's work number and make an emergency call. The two of them believe that my action saved his life, but I have no proof of that.

19. Trying to have a conversation with Mr. Pugh is very difficult and depressing since I remember the quality of his speech and brain power from my dealings with him before he was struck down. Here is one direct quote from our December 6, 2008 conversation: "I know that I must have done work for you or your company but I can't remember anything I did for you." The situation, therefore, has not changed since Bob McGuire travelled to Connecticut last year and had a similar comment from Mr. Pugh: Mr. Pugh is unavailable to answer any questions about anything, let alone anything relevant to the petition, nor can anyone else answer on his behalf.

20. I hereby declare that all statements made herein of my own knowledge are true and that all statements made on information and belief are believed to be true; and further that these statements were made with the knowledge that willful false statements and the like so made are punishable by fine or imprisonment, or both, under § 1001 of Title 18 of

the United States Code and that such willful false statements may jeopardize the validity of the application or any patent(s) issued thereon.

Executed in Mobile, AL (location)

Date: 20 Feb 2009

By: Joseph C. Murray

EXHIBIT A

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MOBILE ALABAMA 36608

3719 DAUPHIN STREET
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**MURRAY, JOSEPH C**

PHYSICIAN: **BRADLEY DAVIDSON, M.D.**

PATIENT NO: 0241462 MRN: 226266 PATIENT CLASS: I
ADM DATE: 10/31/2002 DATE OF PROCEDURE: ROOM: 1017

**OPERATIVE REPORT**

cc: DAVIDSON, Admitting Physician

SURGEON: Dr. Bradley S Davidson.

ASSISTANT: Dr. Lee Thompson
Eva Bernacik, PA-C.

PREOPERATIVE DIAGNOSIS: Cancer of the rectum.

POSTOPERATIVE DIAGNOSIS: Cancer of the rectum.

PROCEDURE:
1. Left subclavian central line placement.
2. Exploratory laparotomy.
3. Low anterior resection with primary stapled end-to-end anastomosis.
4. Abdominal node dissection.
5. Temporary diverting ileostomy.
6. Placement of Foley catheter.

ANESTHESIA: General endotracheal.

INDICATIONS: There is a 65-year-old gentleman who presented with urgency and rectal bleeding. He was found to have an adenocarcinoma of the mid to upper rectum. After appropriate preoperative staging, he was scheduled for a low anterior resection.

SUMMARY: The patient underwent central line placement for fluid management during and after the operation. At exploration, he had no obvious evidence of metastatic disease and low anterior resection was performed. The stapled anastomosis developed a leak and was repaired. Because it was somewhat tenuous and fairly low-lying, I decided to do a temporary diverting ileostomy.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room. After satisfactory adequate general endotracheal anesthesia, the patient's left upper chest was prepped and draped in a sterile fashion. A needle was used to cannulate the left subclavian vein and a central line was placed without difficulty and sutured to the skin. A dressing was applied.

Next, the patient was placed in the lithotomy position and the abdomen was prepped and draped in a sterile fashion. A Foley catheter was placed sterilely and draped over the right leg. The patient was draped in a sterile fashion and a lower midline incision was made in the skin and taken down through the subcutaneous tissues. All bleeders were controlled with the electrocautery. The abdomen was entered and explored. High on the dome of the liver were two very small palpable lesions; one was thought to be a bile duct adenoma and the second was probably no more than 3 mm in diameter and was probably benign. It was extremely difficult to even come close to seeing this, and I decided to abort as I felt they were probably benign.

A Bookwalter retractor was applied and the sigmoid colon was mobilized in a standard fashion along the left gutter. This continued with dissection of the abdomen, _____ (s/l tissial ) plane, and the entire mesentery of the sigmoid colon. The ureter fell back on the retroperitoneum as the dissection continued over the iliac vessels. This continued to the patient's right where the second ureter was identified and preserved.

The bowel was divided with a GIA stapler in the mid sigmoid colon and the mesentery was taken down in a retrograde fashion clamping and tying all vessels. Dissection continued upon the inferior mesenteric artery where it

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MICHEL H. SHAIN, M.D.
CAROL B. COOKE-DITTMANN, M.D.
BURSON T. WILLIAMS, M.D.

SURGICAL PATHOLOGY REPORT

| PATIENT DATA | DATE: | DOCTOR: | ROOM: | ACCN. NO.: |
|---|---|---|---|---|
| MURRAY,JOSEPH<br>241462 226266 | 10/31/2002 | DAVIDSON, B SCO | 10171 | M-5359-02 |
| 65Y M 07/04/1937 | TISSUES SUBMITTED:<br>COLON SEGMENT. MESOCOLON. | | | |

DATE OF SURGERY: 10/31/02

PRE-OP DIAGNOSIS: Colon CA
POST-OP DIAGNOSIS: Same
OPERATION: Colon resection

GROSS DESCRIPTION: The first specimen is labeled "colon segment." The specimen is received in the fresh state at the time of surgery and consists of a segment of large bowel measuring 22 x 7.5 x 5.0 cm. The bowel segment varies from 5.0 to 6.0 cm in greatest diameter. The specimen is opened longitudinally and an ulcerated tumor mass is identified, it measures 5.7 x 4.5 cm. The frankly ulcerated zone measures 3.5 cm in greatest diameter. The tumor mass is located 2.5 to 3.5 cm from the distal margin which is grossly free of tumor. The deep soft tissue margin is grossly free of tumor. The tumor appears localized 2 cm from the deep margin. Sections are representative labeled as follows: A1 - distal margin; A2 - proximal margin, A3, 4 and 5 - main tumor mass; A6 - deep soft tissue margin inked with black ink. Mesocolic nodes in the vicinity of the main tumor mass are contained in A7 and A8. Near the peritoneal reflection several nodes are identified which average 0.7 cm in greatest dimension. They are submitted in cassette A9. Lymph nodes in the proximal bowel remote from the tumor mass are contained in A10. Additional lymph nodes near the peritoneal reflection are submitted in A11. Otherwise the colonic mucosa is tan-pink and thrown into transverse folds. No additional lesions are identified grossly. Also received at the time of surgery is a plate of adipose tissue with a suture tie at the proximal surgical margin. The specimen overall measures 11.5 x 7.2 x 3.1 cm. Lymph nodes at the suture tie are contained in B1. The nodules vary from 0.2 up to 1.4 cm in greatest dimension. The nodes are tan-pink and glistening. No grossly positive nodes are apparent. BCW:ehl (29; 09; 07; B18)

The third specimen is labeled "true distal margin". The segment measures 4.5 x 2.4 x 1.0 cm. Sections are representative labeled C and the remainder is retained as stock.

The fourth specimen is labeled "true proximal margin" and the segment of tan-pink tissue measures 2.7 x 2.0 x 1.3 cm. No mass lesions are identified. Sections are representative in a single cassette labeled D. BCW:lkh (B2)

INTRAOPERATIVE CONSULTATION: WITH GROSS EXAMINATION: COLON SEGMENT, A-MUCOSAL MARGINS ARE FREE OF INVOLVEMENT; THE DISTAL MARGIN IS CLEAR BY 2.5 TO 3.5 CM; THE CLAMPED SEPARATELY SUBMITTED PORTION OF MESOCOLON IS MARKED WITH A BLACK SUTURE AT THE SURGICAL MARGIN. (BCW)

DATE REPORTED: 11/01/02
MURRAY,JOSEPH

BCW
BRIAN C. WENZEL, M.D.

FINAL DIAGNOSIS: (BASED ON GROSS AND MICROSCOPIC EXAMINATION):

I. COLON SEGMENT (LOW ANTERIOR SECTION, A):

1) MODERATE TO POORLY DIFFERENTIATED COLONIC ADENOCARCINOMA, INVADING THROUGH THE MUSCULARIS PROPRIA INTO THE ADJACENT FIBROADIPOSE TISSUE; THE ATTACHED MUCOSAL MARGINS AND DEEP MARGIN ARE FREE OF INVOLVEMENT.

2) ATTACHED MESOCOLIC LYMPH NODES - 1 OF 12 NODES CONTAINS METASTATIC COLONIC-TYPE ADENOCARCINOMA (SEE COMMENT). 1/12

3) SMALL DIVERTICULAE.

II. LYMPH NODES, 16 (INFERIOR MESENTERIC LYMPH NODES, B):

1) REACTIVE HYPERPLASIA. 0/16

2) NEGATIVE FOR METASTATIC CARCINOMA.

III. COLONIC MUCOSA (TRUE DISTAL MARGIN, C):

NO TUMOR IDENTIFIED.

IV. COLONIC MUCOSA (TRUE PROXIMAL MARGIN, D):

NO TUMOR IDENTIFIED.

COMMENT: The tumor is moderate to poorly differentiated colonic adenocarcinoma with areas of necrosis en mass. Although there is extensive lymphatic permeation in the mesocolon, only one small positive lymph node is identified in the vicinity of the main tumor mass (A4). According to Dukes' classification the lesion is stage C1 and according to the Astler-Coller classification the lesion is stage C2.

BCW:ehl

T, M.

DATE REPORTED: 11/01/02
MURRAY,JOSEPH

BCW

BRIAN C. WEINZEL, M.D.

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MURRAY, JOSEPH C

PHYSICIAN: BRADLEY DAVIDSON, M.D.

PATIENT NO: 0257116 MRN: 226266 PATIENT CLASS: I
ADM DATE: 12/16/2002 DATE OF PROCEDURE: ROOM: 1211

**OPERATIVE REPORT**

cc: DAVIDSON, Admitting Physician

SURGEON: Bradley Davidson, M.D.

ASSISTANT: Brian _____ (s/l McClure?)

PREOPERATIVE DIAGNOSIS:
Cancer of the rectum, status post diverting ileostomy.

POSTOPERATIVE DIAGNOSIS:
Cancer of the rectum, status post diverting ileostomy.

PROCEDURE:
Ileostomy closure with resection.

ANESTHESIA: Endotracheal.

INDICATIONS: This is a 65-year-old gentleman who presented with a low lying rectal cancer. He underwent a low anterior resection and a diverting ileostomy. He is now scheduled for reversal.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room. After establishing adequate general endotracheal anesthesia, the ileostomy site was cleaned and closed with a running 2-0 silk suture. The abdomen was prepped and draped in sterile fashion. An elliptical incision was made in the skin around the ileostomy site. This was taken down through the subcutaneous tissues down to the fascia. Both limbs of the ileostomy were freed up circumferentially and the abdominal cavity was entered. All adhesions were taken down and the two limbs of bowel were brought up into the wound. Bowel clamps were placed proximally and distally and the bowel was divided proximally and distally with electrocautery. The mesentery was taken down between clamps and tied with 3-0 silk suture.

Next, an anastomosis was performed using a 3-0 Maxon running simple single layer suture. This was reinforced with several interrupted 3-0 silk sutures. The area was irrigated copiously with normal saline and this was dropped into the abdominal cavity and then the abdomen was irrigated copiously with normal saline. The incision was then closed with a running #2 Vicryl suture. Care was taken to include both the deep and superficial rectus fascia with this running closure. Subcutaneous tissues were irrigated with normal saline and closed with several interrupted 3-0 Vicryl sutures and the skin was closed with interrupted 3-0 nylon sutures in a vertical mattress fashion. The patient was awakened, extubated and taken to the recovery room in stable condition. Time of procedure was about one hour.

D:12/16/2002 09:31:00/T:12/16/2002 13:22:50/dd/ID#446206 BRADLEY DAVIDSON, M.D.
"I AUTHORIZED MY NAME TO BE ELECTRONICALLY AFFIXED BY USING MY UNIQUE DICTATION COMPUTER KEY."

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BURSON T. WILLIAMS, M.D.

SURGICAL PATHOLOGY REPORT

| PATIENT DATA | DATE: | DOCTOR: | ROOM: ACCN. NO.: |
|---|---|---|---|
| MURRAY,JOSEPH<br>257116 226266 | 12/16/2002 | DAVIDSON, B SCO | 12111 M-6024-02 |

TISSUES SUBMITTED:

65Y M 07/04/1937 RESECTION OF ILEOSTOMY.

DATE OF SURGERY: 12-16-2002

PRE-OP DIAGNOSIS: CA rectum, ileostomy
POST-OP DIAGNOSIS: Same
OPERATION: Ileostomy closure

GROSS DESCRIPTION: The specimen is labeled "resection of ileostomy" and the specimen consists of a cylindrical segment of bowel with attached skin with an opening sutured by tan suture. Overall the specimen measures 8 x 4.2 x 3.0 cm. The mucosa is glistening and tan-pink. Mucosal folds are transversely oriented. No mass lesions are identified. Sections are representative in two cassettes. BCW:lkh (04; B2)

FINAL DIAGNOSIS: (BASED ON GROSS AND MICROSCOPIC EXAMINATION):

ILEOSTOMY:

1) SUTURE GRANULOMA.
2) NEGATIVE FOR MALIGNANCY.

BCW:lkh

DATE REPORTED: 12-17-2002
MURRAY,JOSEPH

BRIAN C. WENZEL, M.D.

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MURRAY, JOSEPH C

PHYSICIAN: BRADLEY DAVIDSON, M.D.

PATIENT NO: 0268826 MRN: 226266 PATIENT CLASS: O
ADM DATE: 01/16/2003 DATE OF PROCEDURE: ROOM:

**OPERATIVE REPORT** cc: DAVIDSON, Admitting Physician

PREOPERATIVE DIAGNOSES:
1. Cancer of the rectum.
2. Need for IV chemotherapy.

POSTOPERATIVE DIAGNOSES:
1. Cancer of the rectum
2. Need for the IV chemotherapy.

PROCEDURE: Left subclavian Groshong catheter placement.

SURGEON: Dr. B. Davidson

ASSISTANT: Carol Ramel, CRNP

ANESTHESIA: MAC with local.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and after adequate IV sedation, the patient's left upper chest was prepped and draped in a sterile fashion. After infusing 1% Lidocaine in the subclavian area, a needle was used to cannulate the left subclavian vein. A guidewire was placed and placement was confirmed by fluoroscopy. This was followed by dilator and an introducer sheath, followed an 8 French single-lumen Groshong catheter. This was advanced to about 20 cm and placement was confirmed with fluoroscopy. It was then tunneled under the skin into the left upper chest. It was aspirated of blood without difficulty and flushed and then attached to the skin with the clasp and a 3-0 Nylon suture. 4-0 Vicryl was placed in the subclavian area. Following placement, placement was confirmed again by fluoroscopy and it was aspirated and flushed again. The patient was awakened and taken to the recovery room in stable condition.

D:01/16/2003 14:42:00/T:01/16/2003 20:03:55/dd/ID#457798 BRADLEY DAVIDSON, M.D.
"I AUTHORIZED MY NAME TO BE ELECTRONICALLY AFFIXED BY USING MY UNIQUE DICTATION COMPUTER KEY."

SPRINGHILL MEMORIAL HOSPITAL

Radiological Consultation

HOSPITAL #: 00268826

DATE: 01/16/03

LOCATION: *O/P

ORDERING PHYS: DAVIDSON,BRADLEY

NAME: MURRAY,JOSEPH C
ADDRESS: 5922 WINDHAM COURT MOBILE AL 36608

Age: 65Y Sex: M DOB: 07/04/37 MR Number: 00226266

| Chk-in # | Order | Exam | |
|---|---|---|---|
| 318761 | 0003 | 1041 | XR CHEST AP ONLY |

Ord Diag: POST-OP GRONSHONG PLACEMENT** Portab

AP PORTABLE CHEST X-RAY, 1510, 16-JANUARY 03:

COMPARISON: AP portable chest x-ray, 31-October 02.

FINDINGS: The lungs are clear. The tip of the left subclavian central venous catheter overlies the expected region of the superior vena cava. The heart size is normal. There is atherosclerotic calcification of the thoracic aorta. There is no evidence of pneumothorax. The skeletal structures are unremarkable.

IMPRESSION: NO ACUTE CARDIOPULMONARY DISEASE.

ABBIE IN THE TRANSCRIPTION WAS REQUESTED TO CALL THE ABOVE REPORT TO RECOVERY AT 1532 ON 16-JANUARY 03.

/Read By/ DONALD WAGNON, M.D.
/Released By/ DONALD WAGNON, M.D.

AAH

Mobile Infirmary Medical Center

**Mobile Infirmary Medical Center**

*P.O. Box 2144*
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DEPARTMENT OF PATHOLOGY

*F.T Boudreaux, M.D.*
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*Lee F. Fucich, M.D.*
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*Kelly P. Roveda, M.D.*
*Regan L. Cardamone, M.D.*
*Allison L.T. Graves, M.D.*

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# SURGICAL PATHOLOGY REPORT

| Patient | MURRAY, JOSEPH | Case no: | SS-5130-05 |
|---|---|---|---|
| Hospital No: | 7O23887 | Sex: | M |
| Physician: | LEE THOMPSON | DOB/Age: | 07/04/1937(67 Y) |
| Collected: | 05/05/2005 | MRN No: | 199284275 |
| Received: | 05/05/2005 | Room/Ward: | 4654*/SURGERY |
| Chart No.: | | Reported: | 05/09/2005 |

**CLINICAL HISTORY:**
LIVER CANCER

**OPERATION/PROCEDURE:**
RIGHT HEPATIC LIVER LOBECTOMY, CHOLECYSTECTOMY AND EXCISION OF CAPSULE OF ADRENAL GLAND

**TISSUE (S) SUBMITTED:**
(A) ADRENAL GLAND
(B) LIVER LOBECTOMY, lesion, segment 7
(C) GALLBLADDER

**INTRAOPERATIVE CONSULTATION:**
**FS. (A) NEGATIVE FOR TUMOR. /LFF**
**ORC (B) MARGINS CLEAR. /LFF**

**GROSS DESCRIPTION:** Capsule of adrenal gland: The specimen is received in the fresh state at the time of surgery and a frozen section was performed. The specimen is submitted in toto as A.

B is labeled lesion, segment 7 (products of right hepatic lobectomy). The specimen consists of a formalin fixed mass of liver tissue which weighs 348.3 grams and measures 13 x 9 x 7 cm in its greatest dimensions. The parenchymal surgical margin has been previously inked and examined at the time of intraoperative consultation. Margins were reported as grossly free of involvement. Within the liver resection there is a 5.6 cm grayish tan tumor mass which extends to within 0.5 cm of the ink surgical margin at its nearest point. Tumor also appears to involve the hepatic capsule peripherally. The following sections are taken. Sections taken of the inked parenchymal surgical margin are submitted for study as B1 and B2, B3. sections of the hepatic neoplasm to include the capsular margin, B4. random sections of the hepatic neoplasm. SM:S

C is labeled gallbladder and consists of a formalin fixed gallbladder which has been amputated through a short segment of attached cystic duct. The gallbladder measures 7 x 3 cm in its greatest dimensions. The serosal surface is smooth and glistening and the wall averages 0.3 cm in diameter. The lumen contains copious amounts of tenacious green bile without evidence of cholelithiasis. Cholesterolosis is identified. No obstructing lesions are identified proximally and representative sections are submitted for study as C. S2:S LLG/SBL

**DIAGNOSIS:**
**A. ADRENAL GLAND CAPSULE, EXCISION:**
**NEGATIVE FOR TUMOR.**

**B. LIVER, SEGMENT 7, RIGHT HEPATIC LOBECTOMY:**
**METASTATIC ADENOCARCINOMA CONSISTENT WITH COLORECTAL ORIGIN.**
**SURGICAL MARGINS NEGATIVE FOR TUMOR.**

**C. GALLBLADDER, CHOLECYSTECTOMY:**
**CHOLESTEROLOSIS.**
**NO STONES IDENTIFIED.**

GAN/GAN

**INTRADEPARTMENTAL CONSULTATION:** GLENN A. NELSON, MD, PATHOLOGIST
Slide B1 only ,Agree-KPR

G.A. Nelson, MD

GLENN A. NELSON, MD, PATHOLOGIST

OPERATIVE REPORT 7023887.OPA

DATE: 05/05/2005
SURGEON: LEE W THOMPSON
ASST. SURGEON:
ANESTHETIST: JERRY L HENNIG
INSTR. NURSE: ERICA LYNN SHIVER
INSTR. NURSE RELIEF: BRENDALYN NICHOLAS
CIRC. NURSE: TERRI ELMORE
CIRC. NURSE RELIEF: RENAE SANDERS
RETRACTING NURSE:

4291

PREOPERATIVE DIAGNOSIS: COLORECTAL METASTASIS TO THE RIGHT LOBE OF THE LIVER.

POSTOPERATIVE DIAGNOSIS: COLORECTAL METASTASIS TO THE RIGHT LOBE OF THE LIVER.

OPERATION:
1. SEGMENTAL RESECTION OF SEGMENT IV OF THE LIVER WITH PARTIAL RESECTION OF ADJACENT SEGMENTS FOR COLORECTAL METASTASIS.
2. INTRAOPERATIVE ULTRASOUND.
3. CHOLECYSTECTOMY.
4. CENTRAL LINE PLACEMENT.
5. PLACEMENT OF SUBCUTANEOUS PAIN PUMP.

ASSISTANT: EVA BERNACIK, PA-C.

ANESTHESIA: GENERAL.

ESTIMATED BLOOD LOSS: 400 CC.

BRIEF HISTORY: This is a 67-year-old male who had a previous history of colorectal cancer, resected. He had rising CEA. Lower endoscopy was not revealing, but CT scan demonstrated lesion within the right lobe of the liver. Risks, benefits and alternatives of resection were explained to the patient and his family, and he was consented for surgery.

PROCEDURE: This 67-year-old male was brought to the operating suite and laid in the supine position. General anesthesia was induced. His anterior abdomen was prepped and draped in the usual sterile fashion after appropriate lines and tubes were placed. A subcostal incision was made and the abdomen entered without complication. A few small adhesions were taken down. The liver was ultrasounded and again demonstrated very nicely the lesion in the right lobe of the liver. It was within 2 cm of the main right hepatic vein. The right hepatic vein

OPERATIVE REPORT 7067629.OPA

DATE: 05/30/2005
SURGEON: LEE THOMPSON, M.D.
ASST. SURGEON:
ANESTHETIST: MICHAEL H LASECKI
INSTR. NURSE: CRYSTAL LEE MOQUIN
INSTR. NURSE RELIEF:
CIRC. NURSE: RENAE SANDERS
CIRC. NURSE RELIEF:
RETRACTING NURSE:

4291

PREOPERATIVE DIAGNOSIS: NEEDED INTRAVENOUS ACCESS FOR CHEMOTHERAPY.

POSTOPERATIVE DIAGNOSIS: NEEDED INTRAVENOUS ACCESS FOR CHEMOTHERAPY.

OPERATION:
1). PLACEMENT OF LEFT GROSHONG CATHETER USING FLUOROSCOPY.
2). INTRAOPERATIVE ULTRASOUND.

ANESTHESIA: SEDATION WITH LOCAL INFILTRATION OF 0.25% MARCAINE WITH EPINEPHRINE.

DESCRIPTION AND FINDINGS: Patient was brought to the operating room and laid in the supine position. Intraoperative ultrasound was used to verify patent and position of left subclavian vein. This was marked preoperatively. We then prepped and draped in the neck and chest in the usual sterile fashion. 0.25% Marcaine was infused locally. Introducer needle was placed with in the vein, and a wire into the vein. Position was confirmed using fluoroscopy. We then placed a dilator and sheath over this wire. The catheter was placed through this, and again position confirmed with fluoroscopy. The catheter was then tunneled to the anterior chest all and secured into position. The puncture site was closed in two layers.

Patient tolerated the procedure well with less than 10 cc of blood loss. Chest x-ray was pending in the recovery room.

cc:

PATIENT'S NAME: MURRAY JOSEPH C
SOCIAL SECURITY NO: 19928-42-75
HOSPITAL NUMBER: 7067629
ADMISSION DATE: 05/30/2005
ROOM#:

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OPERATIVE REPORT LWT/cer

LEE W. THOMPSON, M.D.

DICTATION DATE: 05/30/2005 09:47

TYPING DATE: 05/30/2005 10:15

branched and one of the branches went right across the tumor. The portal segments were followed and segment 7 portal structures went right into the area of this tumor. The bifurcation was approximately 3 cm away. The remaining portion of the liver appeared clear. Also, no lesions were palpated. The liver was otherwise normal. The falciform was carefully taken down and the hepatic veins identified. The right lobe of the liver was mobilized. Some small branches going off into the inferior vena cava were carefully taken. One long bridging area was divided and oversewn using Prolene suture. The tumor easily mobilized off the retroperitoneum and adrenal gland. Since there was such a thick capsule of the adrenal gland, just to be sure we did not have tumor invasion we sent the capsule of the adrenal gland, and this did not have any tumor within it. We isolated the right hepatic vein with a vessel loop. We then marked the area and used ultrasound to identify our level of crossing the hepatic parenchyma. We used a Tissue-Link to carefully open and perform a 1 cm around the cut surface within the liver to ensure adequate plane. We again ultrasounded to again ensure we came to the appropriate plane. We then used multiple loads of the white vascular load on the GIA and divided the liver parenchyma and vessels using this. We made very small advances, and this went without difficulty. We went right down the right hepatic vein actually leaving its edge visualized along the cut surface of the liver. We then brought this specimen out and had the pathologist freeze this. We had pathology evaluate this grossly for margins, and it was a very adequate gross margin of about 0.5 to 1 cm. The closest margin was the area at the right hepatic vein. The right hepatic vein would have needed taking for further margin. We then took the gallbladder down from the fundus to the cystic duct. The artery was tied. The duct was tied and clipped. We had a lap placed on the surface of the liver and did not see any further bile leak or bleeding. The Tissue-Link was used to ensure coagulation of the surface. We then evaluated the rest of the abdomen with no abnormalities. The skin was closed using a running #1 PDS. A subcutaneous pain pump was placed in the subcutaneous tissue for local anesthetic for postoperative pain relief. The skin was closed using a running #3-0 Vicryl in subcuticular fashion. The patient tolerated the procedure well with no complications.

Approximately 400 cc of blood loss.

cc:

PATIENT'S NAME: MURRAY JOSEPH C
SOCIAL SECURITY NO: 19928-42-74
HOSPITAL NUMBER: 7023887
ADMISSION DATE: 05/05/2005
ROOM#: AM55C

OPERATIVE REPORT LWT/djh

DICTATION DATE: 05/05/2005 13:33

TYPING DATE: 05/05/2005 09:41

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LEE W. THOMPSON, M.D.

Mobile Infirmary Medical Center

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DEPARTMENT OF PATHOLOGY

*F.T Boudreau, M.D.*
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*John J. Lazarchick, M.D.*
*Kelly P. Roveda, M.D.*
*Regan L. Cardamone, M.D.*
*Allison L.T. Graves, M.D.*

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# SURGICAL PATHOLOGY REPORT

| Patient | MURRAY, JOSEPH | Case no: | SS-1973-06 |
|---|---|---|---|
| Hospital No: | OPE9823 | Sex: | M |
| Physician: | LEE THOMPSON | DOB/Age: | 07/04/1937(68 Y) |
| Collected: | 02/14/2006 | MRN No: | 199284275 |
| Received: | 02/14/2006 | Room/Ward: | /SENT TO LAB |
| Chart No.: | | Reported: | 02/15/2006 |

**CLINICAL HISTORY:**
MALIGNANT NEOPLASM OF LIVER, LESION; LEFT THIGH

**OPERATION/PROCEDURE:**
REMOVAL

**TISSUE (S) SUBMITTED:**
SKIN, EXCISION, left thigh

**GROSS DESCRIPTION:** Excisional biopsy, lesion, left thigh: It consists of several fragments of pink to yellowish white soft tissue measuring 1.4 cm in aggregate. Filtered and embedded, labeled A. SM:0S JIM/HMF

**DIAGNOSIS:**
**SKIN, THIGH, LEFT, EXCISION:**
**KERATINOUS CYST, EPIDERMAL INCLUSION TYPE, RUPTURED WITH FOREIGN BODY GIANT CELL REACTION.**
LLG/HMF

LLOYD L. GARDNER, MD, PATHOLOGIST
2/20/06
Path report called